SAMPLE

Mental Retardation Community Medicaid Services

____ **NEW**
FOR CSP YEAR

____ **REVISION**
FOR CSP YEAR

Consumer-Directed Companion Services

INDIVIDUAL SERVICE PLAN

Individual: _____ Medicaid Number:_____

Services Facilitator/Agency:_____SF Provider Number:_____

Services Facilitator Telephone Number:_____Services Facilitation Start Date: _____

Designated Backup:_____Telephone:_____

ISP Start Date: _____ Quarterly Review Dates:_____ _____ _____ _____

SUPPORT GOAL/OUTCOME: *To be as independent as possible in my home and community.*

PURPOSE OF SUPPORT *(Examples in italics.)*	WHEN SUPPORT IS PROVIDED	WHERE AND HOW SUPPORT WILL BE PROVIDED *(Examples in italics.)*
1. To get ready for work.	*Work day mornings (M – F) from 7:30 - 9:00*	*In my home, my companion will help me prepare and eat breakfast, take my medications, pack a lunch and catch the bus.*
2. To be involved in the community	*Wed 6-9 pm Sat 1-5 pm Sun 11-2pm*	*My companion will help me schedule and accompany me to places and activities in the community, such as the Lion's Club, shopping, church, restaurants, visiting friends, and other activities that arise. He will assist me in scheduling and using Medicaid Taxi, paying for purchases, eating, taking my medications and safely negotiating the streets.*
